PROPERTY & CASUALTY INSURERS

COMPANY NAME: _____ **NAIC Company Code:** _____
Contact: _____ **Telephone:** _____
REQUIRED FILINGS IN THE STATE OF: MONTANA **Filings Made During the Year 2009**

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES* Domestic State	Domestic NAIC	Foreign State	(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½" x 14")	1	EO	xxx	3/1	NAIC	A thru N
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	A thru N
	2	Quarterly Financial Statement (8 ½" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	A thru N
	3	Protected Cell Annual Statement	0	0	xxx	3/1	NAIC	A thru N
	4	Combined Annual Statement (8 ½" x 14")	0	EO	0	5/1	NAIC	A thru N
		II. NAIC SUPPLEMENTS						
	10	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	11	Actuarial Opinion Summary	0	N/A	xxx	3/15	Company	A thru N, Y
	12	Combined Insurance Expense Exhibit	1	EO	xxx	5/1	NAIC	A thru N
	13	Credit Insurance Experience Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	14	Exceptions to Reinsurance Attestation Supplement	1	NA	xxx	3/1	Company	A thru N
	15	Financial Guaranty Insurance Exhibit	1	EO	xxx	3/1	NAIC	A thru N
	16	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	A thru N
	17	Insurance Expense Exhibit	1	EO	xxx	4/1	NAIC	A thru N
	18	Long Term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	A thru N
	19	Management Discussion & Analysis	1	EO	xxx	4/1	Company	A thru N
	20	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	A thru N
	21	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	22	Premiums Attributed to Protected Cells Exhibit	1	EO	xxx	3/1	NAIC	A thru N
	23	Reinsurance Attestation Supplement	1	EO	xxx	3/1	Company	A thru N
	24	Reinsurance Summary Supplemental	1	EO	xxx	3/1	NAIC	A thru N
	25	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	A thru N
	26	Schedule SIS	1	N/A	N/A	3/1	NAIC	A thru N
	27	Statement of Actuarial Opinion	1	EO	xxx	3/1	Company	A thru N, Y
	28	Supplement A to Schedule T	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	29	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A thru N
	30	Trusteed Surplus Statement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
		III. ELECTRONIC FILING REQUIREMENTS						
	40	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	41	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	42	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	43	Risk-Based Capital .PDF Filing	xxx	1	N/A	3/1	NAIC	
	44	Combined Annual Statement Electronic Filing	xxx	1	xxx	5/1	NAIC	
	45	Combined Annual Statement .PDF Filing	xxx	1	xxx	5/1	NAIC	
	46	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	47	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	48	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	49	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	50	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	61	Accountants Letter of Qualifications	1	N/A	N/A		Company	A, B, E, I, J, K, X
	62	Audited Financial Statements	1	EO	xxx	6/1	Company	A, B, E, I, J, K, X
	63	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	A, B, E, I, J, K, X
	64	Independent CPA	1	N/A	N/A		Company	A, B, E, I, J, K, X
	65	Notification of Adverse Financial Condition	1	N/A	N/A		Company	A, B, E, I, J, K, X
	66	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	A, B, E, I, J, K, X
	67	Request for Exemption to File	1	N/A	N/A		Company	A, B, E, I, J, K, X
	68	Request to File Consolidated Audited Annual Statements	1	N/A	N/A		Company	A, B, E, I, J, K, X
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	A, B, E, O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	A, B, E, P
	103	Copy of Annual Statement Montana State Page w/Tax Report	1	0	1	3/1	Company	A, B, E
	104	Filings Checklist Page 1 (with Column 1 completed)	1	0	1	3/1	State	A, B, E
	105	Genetics Program Charge Form (SAI 26)	1	0	1	3/1	State	A, B, E, Q
	106	Holding Company Statement	1	0	0	4/30	State	A, B, E
	107	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	A, B, E, R
	108	Montana Comprehensive Health Association (MCHA) Survey	1	0	1	3/1	State	A, B, E, S
	109	Montana Medical Malpractice Professional Liability Experience	1	0	1	3/1	State	A, B, E, T
	110	Montana Premium Tax Report & Remittance (SAI 28)	1	0	1	3/1	State	A thru F
	111	Quarterly Premium Tax Forms (SAI 23)	1	0	1	4/15, 6/15, 9/15, 12/15	State	A, B, D, E, F, U
	112	Report of Insured Montana Residents	1	0	1	3/1	State	A, B, E, V
	113	Small Employer Group Activity Report (SEHRP-08)	1	0	1	3/1	State	A, B, E, W
	114	State Filing Fees	1	0	1	3/1	State	A, B, C, E, F
	115	Signed Jurat	0	xxx	1	3/1	NAIC	A, B, E, L

***If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing). **If Form Source is NAIC, the form should be obtained from the appropriate vendor.**

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	**Required Filings Contact Person**: Montana Insurance Department, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at cdonovan@mt.gov; Michelle Scaccia at mscaccia@mt.gov; Tim Morris at tmorris@mt.gov; Wayne Barker at wbarker@mt.gov
B	**Mailing Address**: Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	**Mailing Address for Filing Fees**: Mailing address is same as above. The fee of $1,900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.
D	**Mailing Address for Premium Tax Payments**: Same as B.
E	**Delivery Instructions**: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day. The premium tax return (SAI 28) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on yellow paper. If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. **DO NOT** combine amounts for groups of companies. Note that the tax return requires all companies remit a check for $1,900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2008, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2009 quarterly premium tax prepayments. Montana Administrative Rules pertaining to tax payments: 6.6.2706 Adjustments (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. 6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.
F	**Late Filings**: The commissioner may impose a fine [Sections 33-2-701(7) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]

G	**Original Signatures**: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	**Signature/Notarization/Certification**: Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	**Amended Filings**: See NAIC Annual Statement Instructions for guidance on amended filings.
J	**Exceptions from normal filings**: Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	**Bar Codes (State or NAIC)**: Montana is not currently using Bar Codes.
L	**Signed Jurat**: Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.
M	**NONE Filings**: See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	**Filings new, discontinued or modified materially since last year**: None of the fillings have been discontinued since last year. New Electronic Filings: Risk-Based Capital .PDF Filing Modified: Genetics Program Charge is $1.00 See Note Q.
O	**Certificate of Compliance**: Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
P	**Certificate of Deposit**: Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders. Due March 1.
Q	**Genetics Program Charge Form** (SAI 26): Pursuant to Section 33-2-712 MCA, an insurer is required to pay a fee of $1.00 to the Commissioner of Insurance per Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is enclosed in your packet if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. **REPORT IS DUE EVEN IF REPORTING ZERO.**
R	**Insurance Department Financial Examination Report**: A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.

S	**Montana Comprehensive Health Association (MCHA) Survey**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. **REPORT IS DUE EVEN IF REPORTING ZERO.**
T	**Montana Medical Malpractice Professional Liability Experience Report:** **2005 legislation requires this report from all Property/Casualty insurers writing medical malpractice professional liability insurance** in Montana [Section 33-23-310, MCA]. Due March 1.
U	**Quarterly Premium Tax Forms and Instructions** (SAI 23): Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2009 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. Include with the 2009 quarterly premium tax remittances a completed voucher form SAI 23. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2009, return all four voucher forms marked "zero" with the April 15 filing. The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.
V	**Report of Insured Montana Residents**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. **REPORT IS DUE EVEN IF REPORTING ZERO.**
W	**Small Employer Group Activity Report** (SEHRP-08): This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. **REPORT IS DUE EVEN IF REPORTING ZERO.**
X	**Audited Financial Statements**: **FOREIGN INSURERS ONLY** – Please refrain from submitting the Audited Financial Statements to this office until further notice.
Y	**Statement of Actuarial Opinion**: Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.

General Instructions
For Companies to Use Checklist

Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.**

Electronic filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) **(Checklist)** Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) **(Line #)** Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) **(Required Filings)** Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions.* This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Risk -Based Capital .PDF Filing*** is the .pdf file for risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplemental .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Statement Electronic Filing*** includes the complete quarterly statement data.

The ***Quarterly Statement .PDF Filing*** is the .pdf file for quarterly statement data.

The ***Combined Annual Statement Electronic Filing*** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The ***Combined Annual Statement .PDF Filing*** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements.

Column (4) **(Number of Copies)** Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail. if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) **(Due Date)** Indicates the date on which the company must file the form.

Column (6) **(Form Source)** This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions.*.

Column (7) **(Applicable Notes)** This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

MONTANA INSURANCE DEPARTMENT
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2008 ANNUAL PREMIUM TAX STATEMENT FIRE COMPANIES CASUALTY COMPANIES

Insurer Name	**NAIC Number**

Company Mailing Address **check if new** ☐	**City**	**State**	**Zip Code**
Tax Contact Mailing Address **check if new** ☐	**City**	**State**	**Zip Code**

State of Domicile	**Tax & Fee Contact Person**	**Tax Contact Person Telephone Number**

Administrative Office Telephone and Fax Numbers	**Toll Free Telephone Number for Policyholder Inquiries**

SCHEDULE A - PREMIUM TAX CALCULATION

1. Total Direct premium income (Ann. Stmt: P/C-pg 19, ln 35, col 1; Health-pg 29, ln 12 & 14, col 1; Title-pg 38, ln 27, col 3, 4, 5) $_____ [1]
2. Finance and service charges (Ann. Stmt: P/C-page 19 footnote a) $_____ [2]
3. TOTAL PREMIUMS COLLECTED (add lines 1 and 2) $_____ [3]
4. Dividends refunded or credited to policyholders (Ann. Stmt.: P/C-page 19, line 35, column 3) $_____ [4]
5. Federal Exemptions - Medicare Title XVIII/Multi-Peril Crop $_____ [5]
6. NET PREMIUMS per 33-2-705(1), MCA (line 3 less line 4 and 5) $_____ [6]
7. PREMIUM TAX per 33-2-705(2), MCA (**2.75% of line 6**) $_____ [7]

SCHEDULE B - FIRE INSURANCE PREMIUM TAX CALCULATION

Taxes are due and payable on the fire portion of the net direct premiums on risks resident, situated or located in Montana. Dollar amount and percentages must be used so that the calculation can be traced to the annual statement. References to rating organizations are not acceptable. Amounts in column IV are to be derived by multiplying amounts in column II by percentages in column III.

	I	II	III	IV	
	LINE OF BUSINESS	**ANNUAL STMT. PG. 19, COL. 1 DIRECT PREMIUM**	**% ALLOCATION OF FIRE RISK**	**DOLLAR AMOUNT OF FIRE PREMIUMS**	
8.	Fire		100%		[8]
9.	Allied Lines				[9]
10.	Farmowners Multi Peril				[10]
11.	Homeowners Multi Peril				[11]
12.	Commercial Multi Peril				[12]
13.	Ocean Marine				[13]
14.	Inland Marine				[14]
15.	Other Private Passenger Auto Liability				[15]
16.	Other Commercial Auto Liability				[16]
17.	Private Passenger Auto Physical Damage				[17]
18.	Commercial Auto Physical Damage				[18]
19.	Aircraft				[19]
20.	Burglary & Theft				[20]
21.	Boiler & Machinery				[21]

22. Total Net Fire Premiums (add lines 8 thru 21, column IV) $_____ [22]
23. Tax on Fire Insurance Premiums per 50-3-109(1), MCA **(2.5% of line 22)** $_____ [23]

CO. NAME _____ NAIC # _____ STATE OF DOMICILE_____

SCHEDULE C -- CALCULATION OF TOTAL TAXES AND FEES

24.	Premium Tax (from line 7)	$_____	[24]
25.	Retaliatory Amount per 33-2-709, MCA (from Schedule E, Line 3 or 4)	$_____	[25]
26.	TOTAL (Add lines 24 and 25)	$_____	[26]
27.	Montana premium tax quarterly pre-payments	$_____	[27]
28.	Overpayments of prior year premium taxes (as confirmed by credit letter)	$_____	[28]
29.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2003-2007, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	$_____	[29]
30.	100% of Assessments paid in 2008 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	$_____	[30]
31.	Empowerment Zone New Employees – tax credit (include copy of certification from Montana Department of Labor and Industry).	$_____	[31]
32.	Gross Deductions (add lines 29, 30 and 31)	$_____	[32]
33.	Allowable Deductions (enter the smaller of line 24 or line 32)	$_____	[33]
34.	Total payments and credits (add lines 27, 28 and 33)	$_____	[34]
35.	If line 26 is larger than line 34, DIFFERENCE is **TAX DUE**	$_____	[35]
36.	**Fire Insurance Premium Tax** (from Schedule B line 23)	$_____	[36]
37.	**COMPANIES MUST REMIT $1,900 IN PAYMENT OF ALL MONTANA FEES**	$ $1,900.00	[37]
38.	**TOTAL REMITTANCE** (add lines 35, 36 and 37)	$_____	[38]
39.	If line 34 is larger than line 26, DIFFERENCE is **ANNUAL TAX OVERPAYMENT**	$_____	[39]

OVERPAYMENT must be carried forward and used to offset future periodic payments.

The above statement, and attached Schedules D and E, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

TAX RETURN CHECKLIST Did You Remember to:

1. _____ Attach Annual Statement Montana State Page?
2. _____ Include Total Remittance from line 38 (at least $1,900)?
3. _____ Attach documentation for tax credits on lines 29, 30 and 31?
4. _____ Indicate your company's NAIC number on front of the tax form?
5. _____ Attach explanations for any unusual or extraordinary items?
6. _____ Fully complete Schedules D and E and attach them to this statement?

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____

SCHEDULE D -- RETALIATORY SCHEDULE
ATTACHMENT TO 2008 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA

	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 6)		
2. Tax Rate	2.75%	
3. Premium Tax		
4. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	$1,900.00	
5. Annual Statement Filing Fee	N/A	
6. Assessment for Insurance Department Operations	N/A	
7. Montana Fire Insurance Premium Tax (from Schedule B, Line 23)		N/A
8. Fire Marshal Tax	N/A	
9. Other Fire Taxes (explain)_____	N/A	
10. Other (explain)_____	N/A	
11. Other (explain)_____	N/A	
12. Total Montana Taxes & Fees (add lines 3 thru 7, col. A)		XXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (add 3 thru 6, and 8 thru 11, col. B)	XXXXXXXXXXX	

SCHEDULE E -- CALCULATION OF RETALIATORY TAX
ATTACHMENT TO 2008 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA

1. Enter Amount from Schedule D, Line 13, Col. B	
2. Enter Amount from Schedule D, Line 12, Col. A	
3. If Schedule E, Line 1 is larger than Schedule E, Line 2 enter difference on this line and transfer this amount to Schedule C, Line 25	
4. If Schedule E, Line 2 is larger than Schedule E, Line 1, enter $0 on this line and transfer $0 to Schedule C, Line 25	

Montana Insurance Department **840 Helena Avenue** **Helena, MT 59601** **(406) 444-2040**	**GENETICS PROGRAM CHARGE**

Name of Company _____ NAIC Number _____

Mailing Address - Street or PO Box No. _____

City, State, Zip _____

Name and Title of Person Completing Form _____ Telephone Number _____ Printed

To be charged upon every HEALTH OR DISABILITY INSURER, HEALTH SERVICE CORPORATION and the MONTANA STATE GROUP HEALTH SELF-INSURANCE PLAN an annual fee of **$1.00** for each Montana resident insured under any individual or group disability or health insurance policy in effect as of February 1 of each year for the purpose of funding the Genetics Program. **FORM MUST BE SIGNED AND RETURNED BY MARCH 1 EVEN IF NOTHING TO REPORT.**

Disability insurance (Section 33-1-207, MCA), including credit disability insurance, is insurance of human beings against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or against disablement or medical expense or indemnity resulting from sickness.

Please provide explanation if fee (or any portion of fee) is not applicable: _____

_____

Number of Montana residents insured under any individual or group health or disability insurance policy in effect as of February 1, 2009 . . . . . _____

Genetics Charge $1.00 . . . . . X 1.00

Total Due . . . (Attach Separate Check for Total Genetics Charge Due) . . . . . _____

Please make your check payable to: Commissioner of Insurance, State of Montana.

(Printed Name of Officer) _____ (Title) _____

(Signature) _____

State of

ss.

County of _____

_____, being duly sworn, says that he/she is an officer of the above named insurance company, and that the foregoing is a full, true and correct statement of the number of Montana residents insured under any individual or group health or disability insurance policy by said company as of February 1, 2009 according to the best of his/her knowledge, information and belief.

Subscribed and sworn to before me this _____ day of _____, 20____.

(Notary Public) _____

Residing at: _____

Commission Expires: _____

11/2008

TO: Company President

FROM: Steve Matthews, Chief Examiner
Montana Insurance Department
840 Helena Avenue, Helena, MT 59601

RE: Montana Comprehensive Health Association (MCHA)

DATE: December 1, 2008

This survey is for all companies licensed to transact Disability (i.e. accident and health) insurance in Montana. A completed survey should be returned **(even if zero premiums are reported**) by **MARCH 1.** If a survey is not returned, assessments will be determined based on the total Montana Accident & Health Direct Premium as shown on the Annual Statement Montana State Page.

You are welcome to return the survey to the address shown above or by facsimile, **406-444-3497**.

Questions #1 and #2 are designed to determine the **five largest individual major medical insurers pursuant to Section 33-22-1512, MCA.** The MCHA plan premiums are based on the "average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force" in Montana.

1. *What is the amount of premiums in force in Montana for individual major medical insurance as of December 31, 2008?* _____

2. *What is the amount of premiums in force in Montana for **association group - individual market type** insurance as of December 31, 2008?* _____

Total ***$*** _____

Question #3 is designed to determine the amount of each insurer's assessment and must include both individual and group policies.

3. Section 33-22-1513, MCA, states each participating member of the association shall share in the losses due to claims expenses of the association by annual assessments not to exceed 1% of the member's *total disability* (i.e. accident and health) insurance premium received from or on behalf of Montana residents, both group and individual. Allowed exclusions from *total disability* (i.e., accident and health) insurance premiums are disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or Medicaid health maintenance organization payments only. Premiums from Federal Employees Health Benefits Plans, Medicare Advantage Plans and Medicare Part D Plans are also allowed exclusions. **Total disability (i.e. accident and health) DOES include premiums from dental, vision, long-term care and Medicare supplemental insurance.**

From Annual Statement Montana State Page (L/H - Pg 24, Ln 26, Col 1) (Fraternal – Pg 23, Ln 26, Col 1) (Health – Pg 29, Ln 12, Col 1) (P/C - Pg 19, Lines 13 thru 15.8)

A. *Total Montana Accident and Health Direct Premiums Written* *$* _____

B. *Allowed Exclusions:* (**DO NOT EXCLUDE** dental, vision, long-term care or Medicare supplemental insurance premiums.)

Disability Income Insurance _____

Disability Waiver Insurance _____

Credit Disability Insurance _____

Life (included in total accident and health) _____

Title XVIII – Medicare Risk Contracts _____

Title XIX – Medicaid Risk Contracts _____

Federal Employees Health Benefits Plan Premiums _____

Medicare Advantage Plans – Federal Part B or Risk _____

Medicare Advantage Plans – Enrollee Portion _____

Medicare Part D Plans – Federal Risk _____

Medicare Part D Plans – Enrollee Portion _____

C. *Total of Exclusions* _____

Total Disability insurance premium written (A minus C) ***$*** _____

Name of insurer: _____ NAIC #: _____

Signature of Officer: _____ Title: _____

Printed or Typed Name of Officer: _____

Assessment Notice Contact Person: _____

Telephone Number: _____ Email: _____

Assessment Notice Mailing Address: _____

Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
406-444-2040

Report of Insured Montana Residents

under health or disability insurance policies
(report due March 1)

FORM MUST BE SIGNED AND RETURNED EVEN IF NOTHING TO REPORT

(Name of Company) (N.A.I.C. #)

(Mailing Address - Street or P.O. Box) (City-State-ZIP)

Section 33-2-704, MCA, requires each insurer providing health or disability insurance to report the number of Montana residents insured under any policy of individual or group health or disability insurance. If your company provides excess of loss or stop loss health or disability insurance, you must also include in your count of covered individuals all Montana residents whose coverage is reinsured in whole or in part by your company. For the purposes of this report, February 1, 2009 should be used as the date for determining the number of Montana residents insured.

An excess of loss or stop loss health or disability insurer may exclude from its count of insured individuals those who have been counted by a primary health or disability insurer or a primary reinsurer. However, the insurer should include in its count the number of individuals it covers under an excess of loss or stop loss health or disability policy for which the individuals have not been counted by a primary insurer. For example, the insurer should include all individuals in its count if excess of loss or stop loss health or disability insurance policies are issued to self-insured employers or plans, multiple employer welfare arrangements, or any other health insurance situations in which first dollar coverage is not provided by a primary insurer.

IMPORTANT!: If the number of Montana residents insured by health or disability insurance is not known, provide an estimate as directed on the reverse side of this form.

1. Number of Montana residents insured under any individual or group health or disability insurance policy, including excess of loss or stop loss insurance policies covering health or disability insurance in effect as of February 1, 2009 _____

2. The number of insured lives reported on line 1 above is based on (check one of the following boxes):

   (a) An actual count of lives insured . . . . . [ ] (actual)

   (b) An estimated count of lives insured, pursuant to the directions on the reverse side of this form . . . . . [ ] (estimate)

The foregoing is a full, true and correct statement according to the best of my knowledge, information, and belief.

(Signature of Officer) (Date)

(Printed name and title of officer) (Telephone number)

INSTRUCTIONS FOR ESTIMATING THE COUNT OF INSURED LIVES

The following are guidelines for estimating the number of insured lives in Montana covered by disability insurance (as defined in 33-1-207, MCA) by your company.

For indemnity and HMO disability insurance plans, estimate this number of insured lives by following these steps. A demonstration of the calculation shown in steps 5 and 6 below, shown separately for each disability insurance policy form with premium volume in Montana, must accompany this estimate.

1. Determine the total 2008 disability insurance premium on policies in force during the year, separately for each policy form.

2. For each policy form, determine the "average plan" sold under that form. Plans may be differentiated by deductible/coinsurance level or by other features unique to specific plans. The "average plan" is the plan which most nearly represents the total plans sold under that policy form. This could be the plan with the highest premium volume, a plan between (in value) two or more plans with significant premium volumes, or a plan selected by some other indication that it fairly represents an average of the plans sold.

3. Determine the gross premium for each average plan for each of the following family categories: (a) a single insured individual; (b) an insured individual and spouse; (c) an insured family (that is, an insured individual, the spouse and the children); and (d) an insured individual and the children. Each gross premium should be based on policyholder characteristics which affect the rates (such as age, geographic area, occupation, etc.) that fairly represent an average for the blocks of business covered by the policy. This yields the average gross premium for each family category for each average plan under each policy form, and is represented by "Average Gross Premium$_y$" in the formula in step 5 below, where "y" refers to one of the four family categories described above.

4. Determine the average distribution of the four family categories above. That is, determine what percent of policies are sold to single individuals, what percent are sold to individual and spouse combinations, and so on. This distribution could change from policy to policy. Each percentage is represented by "Percent$_y$" in the formula in step 5 below.

5. Calculate the policy form's average premium per insured using the formula:

$$\frac{\Sigma_{\text{all y}}\ \text{Average Gross Premium}_y \times \text{Percent}_y}{\Sigma_{\text{all y}}\ \text{Average Number of Insureds}_y \times \text{Percent}_y} = \text{Average Premium per Insured}$$

   The "Average Number of Insureds$_y$" for each family category is as follows: 1 for a single insured individual, 2 for an insured individual and spouse, 4 for an insured family and 3 for an insured individual with children.

6. Calculate the total number of insureds for the policy form as follows:

$$\frac{\text{Total In Force Premium}}{\text{Average Premium per Insured}} = \text{Total Number of Insureds}$$

7. The final step is to add all the estimates of number of insureds under each disability insurance policy form to arrive at a single estimate.

Stop loss and excess of loss insurers must contact each entity insured by these coverages to obtain the number of insureds, including dependents, covered under the contract, and add these counts. The insurer must demonstrate the method of determining the total number by submitting the name of each entity covered under the contract and the total number of insureds covered under each. If this number includes insureds which were counted by a primary insurer, submit the number of lives which were already counted, then subtract that number from the total number to get the number of lives not already counted. Be sure to submit all three numbers.

If you have any questions, please contact Margaret Miksch at (406) 444-3848.

11/2008

Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
406-444-2040

2008
SMALL EMPLOYER GROUP ACTIVITY REPORT

FORM MUST BE COMPLETED AND RETURNED EVEN IF NOTHING TO REPORT
(REPORT DUE MARCH 1)

(Name of Insurance Company) (N.A.I.C. #)

(Mailing Address - Street or P.O. Box) (City - State - Zip)

A.R.M. 6.6.5050(6) of the Small Employer Health Insurance Rules requires reporting of the following information pertaining to health benefit plans covering small groups in Montana. A small group is defined as having employed at least 2 but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. Health benefit plan means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include coverage of excepted benefits if coverage is provided under a separate policy, certificate, or contract of insurance.

1. TOTAL SMALL GROUP MARKET DATA

Total small group premiums written in 2008 $_____

Number of employees covered by policies in force at 12/31/08 _____

Number of dependents covered by policies in force at 12/31/08 _____

ON SEPARATE PAGE, provide the number of small group contracts, by zip code, in force at 12/31/08.

ON SEPARATE PAGE, provide a list of all small employer health benefit plans being actively marketed. Include a list of all form numbers used in connection with these plans, and the date of approval for each form. In the case that a health benefit plan is not being actively marketed, specify the date on which the commissioner was notified that the marketing of this plan would be ceased.

2. HEALTH PLANS NEWLY ISSUED IN 2008

Total number of small group contracts newly issued in 2008 _____

Number of basic health benefit plans newly issued in 2008 _____

Number of standard health benefit plans newly issued in 2008 _____

Number of small group contracts issued to small groups that were uninsured for at least 3 months prior to issue _____

3. HEALTH PLANS RENEWED IN 2008

Total number of small group contracts renewed in 2008 _____

Number of basic health benefit plans renewed in 2008 _____

Number of standard health benefit plans renewed in 2008 _____

Number of small group contracts voluntarily not renewed by employers _____

Number of small group contracts terminated or nonrenewed by carrier in 2008, for reasons other than nonpayment of premium _____

(Type name of person preparing report) (Telephone # and extension) (Email address)

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**CESSATION OF BUSINESS NOTIFICATION FORM** 6.6.2707, ARM

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Contact Person and Telephone Number**	**FEIN #**

Explanation of adjustment to quarterly tax pre-payment.

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20___.

_____(Notary Public)

Residing at _____

My commission expires _____

11/2008

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**PREMIUM TAX REFUND REQUEST FORM** **6.6.2708, ARM**

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Contact Person and Telephone Number**	**FEIN Number**

Reason for decrease in estimated premium tax liability for 2009.

Method of calculation for refund.
Calculation subject to audit by Department

A. 2008 Overpayment $_____

2009 Pre-payment Requirement:

B. 100% of 2008 Tax $_____
or
C. 90% of 2009 Tax * $_____

1. 2008 Overpayment $_____
(A from above)

2. Prepayment required $_____
(B or C from above)

3. Amount of Refund $_____
(1 minus 2)

*** Please explain in left hand column.**

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20 _____.

_____(Notary Public)

Residing at _____

My commission expires _____

11/2008

Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
(406) 444-2040

MONTANA MEDICAL MALPRACTICE PROFESSIONAL LIABILITY EXPERIENCE REPORT

Pursuant to 33-23-310, MCA

Supplement to _____ Annual Statement for _____ (Company)

To be filed March 1 (Surplus Lines - April 1).

REQUIRED INFORMATION - From preceding calendar year	PHYSICIANS	OSTEOPATHS	PODIATRISTS	DENTISTS	OPTOMETRISTS	REGISTERED NURSE	LICENSED PRACTICAL NURSE	ALL OTHER SPECIALTIES	HEALTH CARE FACILITIES as defined by 50-5-101(23), MCA	TOTAL
1. Number of insureds @ December 31										
a. Number of claims-made basis policies										
b. Number of occurrence basis policies										
2. a. Amount of direct premiums paid (written)										
b. Amount of direct premiums earned										
c. Total amount of underwriting expenses (Note in Total column only)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
3. Number of claims made against insureds										
a. Direct losses paid in 3										
b. Direct Case loss reserves in 3										
c. Direct IBNR loss reserves in 3										
d. Direct ALAE paid in 3										
e. Direct Case ALAE reserves in 3										
f. Direct IBNR ALAE reserves in 3										
4. Number of closed claims with direct loss paid										
a. Total amount of direct losses paid in 4										
5. Number of claims open with no direct loss paid										
6. Number of lawsuits filed against insureds										
a. Number of lawsuit claims closed without settlement										
b. Number of lawsuit claims closed with settlement										
c. Total amount paid in settlements in 6b										
8. Number of lawsuits that went to trial										
a. Number of judgments or verdicts for the plaintiff in 8										
b. Number of judgments or verdicts for the insured in 8										
c. Number of other judgments of verdicts in 8										
9. Total of direct losses paid for claims that went to trial and were closed										

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2009

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability *(#7 from tax return)* or 90% of anticipated 2009 tax — $_____
2. Less allowable deductions (*See instructions on back*) — $_____
3. Total 2009 quarterly pre-payment (*line #1 - #2*) — $_____
4. Enter 25% of the amount on line #3 — $_____
5. Amount of 2008 overpayment applied to this payment *(see line #39 of the tax return)* — $(_____)
6. **QUARTERLY AMOUNT REMITTED** *(#4 - #5)* — $_____ (*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (10/08)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2009

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability *(#7 from tax return)* or 90% of anticipated 2009 tax — $_____
2. Less allowable deductions (*See instructions on back*) — $_____
3. Total 2009 quarterly pre-payment (*line #1 - #2*) — $_____
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Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (10/08)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2009

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability *(#7 from tax return)* or 90% of anticipated 2009 tax — $_____
2. Less allowable deductions (*See instructions on back*) — $_____
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Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (10/08)

State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2009

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '08 premium tax liability *(#7 from tax return)* or 90% of anticipated 2009 tax — $_____
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Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (10/08)

QUARTERLY TAX PAYMENT INSTRUCTIONS

Line #2 Instructions

The quarterly amounts should be reduced by subtracting the following **allowable deductions:**

A. Anticipated 2009 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2004-2008): $______________________

B. Montana Comprehensive Health Association assessments: $______________________
(*excluding HIPAA Plan Liability assessments*)

Total allowable deductions to transfer to line #2 (*on front*): $______________________

Other Instructions

Please do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2009.

If insurer deems the total 2009 quarterly pre-payment requirement on line #3 to be a minimal amount (less than $100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2009.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2009 anticipated premium tax.

If you have any questions, please contact our office at (406) 444-2040.

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